# QUESTIONNAIRE

**Please provide the information requested below about your organization.**

**1. Corporate Information**

- **• Name** CIGNA
- **• Address** 1000 Corporate Center Dr.
  Franklin TN 37067
- **• Telephone Number** 800-346-6301
- **• Fax Number** 901-758-5121
- **• E-Mail Address** ww.cigna.com

**2. If a subsidiary or affiliate of a parent organization, corporate information of parent organization**

- **Name** CIGNA
- **Address of Corporate Headquarters** 650 Market Street
  Philadelphia, PA 19103
- **• Telephone Number** 215-761-1000
- **• Fax Number** 215-761-1000
- **• E-Mail Address** ww.cigna.com

**3. State of incorporation or where otherwise organized to do business**

CIGNA HealthCare of Tennessee is a wholly-owned subsidiary of Connecticut General Corporation and is an indirect subsidiary of CIGNA Corporation, a general business corporation, domiciled in Delaware. Both Connecticut General Corporation and CIGNA Corporation are holding companies, and neither is licensed as an insurance company in any state.

**4. States where currently licensed to accept risk and a description of each license**

Connecticut General Life Insurance Company (CGLIC) is licensed to transact the business of insurance by the insurance departments of each of the 50 states, and is subject to the regulation of each of those states within the scope of applicable law. Although there are no federal licenses, CGLIC is subject to all applicable federal laws and regulations.

**5. Contact Information**

- **• Name** Timothy Cullen
- **• Title** Senior Sales Representative
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**6. Program Experience - General**

**Given TennCare's history with small, inexperienced plans becoming insolvent, the State is interested in contracting with MCOs that have substantial experience with capitation, particularly for the Medicaid population. Tennessee also intends to require that all MCOs be NCQA-accredited or receive NCQA-accreditation for the Medicaid product within a specified time period after contract award.**

**a. Do you have at least three years Medicaid experience under capitation? If yes, please identify the states and contract periods. If no, do you have at least three years of experience under capitation in another market?**

Although we do not have Medicaid clients today, in the past we have provided Medicaid coverage to Arizona and California. CIGNA and its predecessor companies have a long history of supporting the health care needs of Americans. Both Connecticut General and Insurance Company of North America (INA), which merged in 1982 to form CIGNA, were among the first major carriers to introduce health care cost-containment and management programs, as well as to explore the development of HMOs.

In 1980, INA acquired the Ross-Loos Medical Group of Los Angeles. Established in 1929, Ross-Loos was the nation's first HMO. By 1990, CIGNA became the largest investor-owned managed care organization in the country and continues to have strong enrollment levels in the industry.

**b. Are you currently accredited by NCQA for your Medicaid product line? If no, are your or any other plans operated by your parent or affiliate NCQA accredited? Which product lines? Would you be willing to become NCQA accredited within a reasonable period of time after contract award? Do you have experience with HEDIS and CAHPS? Please explain.**

Yes. CIGNA has been committed to obtaining third party external accreditation of its Quality Program through the National Committee for Quality Assurance (NCQA) accreditation review process since 1993. As of December 31, 2004, 100 percent of CIGNA U. S. plan locations have gone through the NCQA review process and 100 percent have received either Excellent or Commendable accreditation. These two ratings are the highest ratings a health plan can receive for HMO and POS products. Our 2004 HEDIS Effectiveness of Care results continue to position CIGNA ahead of the industry and our major competitors in a majority of the clinical measures.

CIGNA HealthCare of Tennessee has an Excellent NCQA rating. A copy of our 2004 HEDIS report has been provided in the Exhibits section.

**c. Do you currently contract with any State to provide Medicaid services? If yes, proceed to question 7. If no, proceed to question 10.**

At this time we do not contract with any State to provide Medicaid services.

**7. Medicaid Program Experience - Services**

**Using the list below, please provide a chart that indicates for each of the states where you currently contract: 1) whether you provide the service; and 2) whether you provide the service directly or through a subcontract arrangement.**

**a. Physical Health Benefits**
**b. Dental Benefits**
**c. Vision Benefits**
**d. Non-Emergency Transportation**
**e. Behavioral Health Benefits**
**f. Pharmacy Benefits**
**g. Long-Term Care Benefits (nursing facility and home and community based waiver services)**
**h. Home Health**
**i. Claims Processing and Adjudication**
**j. Quality Assurance**
**k. Utilization Management**
**l. Case Management**
**m. Disease Management**
**n. Provider Credentialing**
**o. Enrollment Assistance**
**p. Member Services (inquiry, id cards)**
**q. Member Grievances/Appeals**

CIGNA serves as the sole provider of services requested to our non-Medicaid clients. However, we have established relationships with subcontractors to enhance our offerings:

| Service | CIGNA Provided | Subcontracted to: |
|---|---|---|
| Physical Health Benefits | ✓ CIGNA HealthCare | |
| Dental Benefits | ✓CIGNA Dental | |
| Vision Benefits | ✓CIGNA Vision or | ✓ Cole Vision |
| Non-Emergency | Services not standardly | |

| Service | CIGNA Provided | Subcontracted to: |
|---|---|---|
| Transportation | provided. | |
| Behavioral Health Benefits | ✓ CIGNA Behavioral Health | |
| Pharmacy Benefits | ✓CIGNA Pharmacy | |
| Long-Term Care Benefits (nursing facility and home and community based waiver services) | Services not standardly provided. | |
| Home Health | | ✓ Gentiva CareCentrix |
| Claims Processing and Adjudication | ✓ | ✓ RX only claims paid through Argus |
| Quality Assurance | ✓ | |
| Utilization Management | ✓ | |
| Case Management | ✓ | |
| Disease Management | | ✓ American Healthways |
| Provider Credentialing | ✓ | |
| Enrollment Assistance | ✓ | |
| Member Services (inquiry, id cards) | ✓ | |
| Member Grievances/Appeals | ✓ | |

**8. Medicaid Program Experience - Population**

**Using the list below, please submit a chart that includes for each of the states where you currently contract: 1) the population(s) served; and 2) the approximate number of individuals served in each population.**

- **• Aged, Blind and Disabled – excluding dual eligibles**
- **• Dual Eligibles: individuals eligible for both Medicaid and Medicare**
- **• TANF and TANF-Related**
- **• SCHIP**
- **• Waiver Expansion Population (low-income uninsured)**
- **• SPMI (Seriously and Persistently Mentally Ill)**
- **• SED (Seriously Emotionally Disturbed Children/Youth)**

The above list is comprised of benefits not standardly offered in employer/employee relationship plans. Since, at this time, we do not contract with State Medicaid programs we cannot provide you with examples of our expertise. Drawing on the combined strength of our registered nurses, physicians, pharmacists and behavioral health professionals, we are confident that, working closely with the State and Tenncare, we will meet these needs and provide cost containment coupled with quality service through our integrated systems and services.

Benefit plans that separate medical, pharmacy and behavioral health may not reflect how your employees and their families view their overall health care needs. More important, you may be missing a powerful opportunity to help individuals with multi-faceted health issues that span the continuum of care.

**9. Medicaid Program Experience – Payment Methodology**

**Please submit a chart that indicates the payment methodology for each state contract, specifically addressing the risk methodology, e.g., full-risk, partial risk, shared risk, etc. Please also describe any financial incentives you currently participate in, including the applicable service(s) and the measures.**

All of CIGNA's prior Medicaid contracts were part of a no-risk arrangement. Our services were provided on an administrative basis. CIGNA does currently cover over 900,000 members which are part of State, County, or Government plans. This is an area of expertise for CIGNA. We have roughly 680,000 members which we cover only administrative basis and 220,000 which CIGNA assumes the full-risk.

**10. Experience – Former Medicaid and/or Commercial**

**If you currently do not contract to provide Medicaid program services, but have in the past, please provide a brief description of the services you provided and the populations you served. Please also indicate the dates of your previous Medicaid contract(s), and indicate the state you contracted with to provide Medicaid services. If you have never contracted to provide Medicaid services, please provide a brief description of the services you provide and the populations/markets you serve.**

Although we do not have Medicaid clients today, in the past we have provided Medicaid coverage to both Arizona and California (2001 to 2005). CIGNA companies comprise one of the nation's leading providers of enrollee benefits, health care coverage, and insurance products to businesses and individuals worldwide.

CIGNA works with many employers around the world including Fortune 500 companies, smaller and mid-size companies, organizations, and institutions – many with multiple sites and employees located across time zones and international borders. CIGNA provides medical benefits through managed care and indemnity health care plans to approximately 9.8 million people, dental coverage to approximately ten million people, behavioral health coverage to approximately 16 million people, and pharmacy benefits to approximately 6.5 million people.

**11. Reformed Managed Care Model**

**As part of its reform efforts, the State of Tennessee intends to return to a capitated managed care delivery system. The State is interested in contracting with experienced plans that are capable of coordinating services across the full continuum of care – from preventive and primary care services to long-term care services, as well as across physical and behavioral health conditions. The MCO benefit package will include behavioral health services, but long-term care services and pharmacy services will continue to be carved-out. As part of this emphasis on management and coordination of care the State intends to include a strengthened disease management strategy designed to manage high cost conditions and to manage care across the**

CIGNA companies comprise one of the nation's leading providers of employee benefits, health care coverage, and insurance products to businesses and individuals worldwide. CIGNA refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, CIGNA Vision Care, Inc., CIGNA Tel-Drug and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or Service Company subsidiaries of CIGNA Corporation and CIGNA Dental Health, Inc.

We have been highly effective at identifying members who benefit from one of our health management programs. Our predictive model is up to 30 percent more accurate than our competitors. Once identified, we have successfully engaged members in the programs that yield positive outcomes – from our HEDIS-leading preventive care programs; to our industry-leading case management programs, including specialty case management; to our CIGNA Well Aware for Better Health$^{SM}$ disease management programs, pioneered with American Healthways.

These activities positively impact member health, which in turn leads to lower total cost to our clients.

CIGNA interacts with about 15 percent of our members through one or more of our clinical programs, including case management, disease management, 24-Hour Health Information Line$^{SM}$ and pre-certification. In addition, another 15 percent of our enrollees receive a targeted outreach through programs that include preventive reminders, as well as educational materials for members with targeted chronic illnesses, such as high blood pressure. In total, we engage about 30 percent of our members through clinical touches or outreaches.

Our Health Management delivers medical cost savings for our clients. Through extensive product offerings, our health management programs can typically deliver between 3.6 percent and 7.4 percent in medical cost savings.

CIGNA Pharmacy Management interacts with physicians to deliver superior outcomes. Our asthma improvement program has delivered a 50 percent reduction in ER visits and hospitalizations for asthma-related conditions. Our cholesterol treatment program identifies outliers and has resulted in a 75 percent reduction in LDL cholesterol levels with 41 percent of participants reaching their LDL cholesterol goal.

**A. Behavioral Health**

**Unlike the current program, the State intends to coordinate behavioral and physical health services through the MCO relationship in order to improve coordination of care. This decision results from (a) the State's previous experience with disputes between the MCO and BHO regarding the responsibilities of each entity for particular patients or diagnoses and (b) the high proportion of behavioral health products and services provided by general and family practitioners and pediatricians, currently beyond the reach of the BHO's expertise. The State also seeks to expand its options relative to the likely bidding pool in order to ensure participation of the broadest array of experienced candidates. Thus, both single-entity, "pure play" BHOs and MCOs, as well as integrated health plans may participate; however, the MCO would be expected to be the primary contractor and to fully manage and coordinate an enrollee's physical health and behavioral health conditions.**

**1. Is your organization currently responsible for providing behavioral health services? If yes, in what state Medicaid programs? Please describe the services you provide and to what populations. Please specify if you serve individuals with serious emotional disturbance (SED) and/or individuals with severe persistent mental illness (SPMI). Please also specify whether you provide these services directly or whether you use a subcontract arrangement. If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured. How/who handles member/provider services, appeals, claims, etc. How is the subcontractor paid?**

Yes. Behavioral health services are provided by CIGNA Behavioral Health (CBH). Behavioral issues are pervasive in the workforce and are primary, if often hidden, drivers of medical costs and productivity loss. It is estimated that stress alone costs U.S. businesses $300 billion annually in lost productivity, absenteeism, accidents, enrollee turnover, worker's compensation awards, and medical, legal, and insurance fees. By choosing CIGNA HealthCare and CIGNA Behavioral Health's (CBH's) behavioral health management program, which functions as a seamless, synchronized, and well-focused component of TennCare's overall health care plan, you can significantly reduce that loss. Simultaneously, your enrollees will be guided to the most appropriate, high quality care by means of a wide range or resources. Comprehensive behavioral management is fundamental to the delivery of superior clinical outcomes in all areas of health care.

For too long, U.S. companies have viewed medical, dental, vision, pharmacy or behavioral benefits as stand-alone services, offering distinct value to enrollees at distinct costs.

We recognize the intrinsic connection between physical and psychological health, mind, and body. Mental illness and substance abuse are endemic in physical disease and medical utilization. Major physical disease harbors profound behavioral challenges for patients. At CIGNA, we leverage our capabilities across these broad areas to help improve consumers' health outcomes, while controlling employer costs.

*Intelligent Integration*

Integration of our top-tier specialty health care services allows us to deliver benefit programs that best provide cost advantages to the state and better health outcomes to the enrollee.

*CIGNA is the only managed care company that owns top tier medical, behavioral, pharmacy and disability programs.*

- Personal Health Solutions$^{SM}$ medical management model is an integrated approach to health facilitation that promotes better outcomes and optimizes your health care investment.
- Care facilitation can deliver differentiated value through our powerful and effective clinical management programs and integration.
- Pharmacy integration uses the combination of medical, pharmacy and lab data to improve medical outcomes.

The CIGNA difference is the way we strike a balance between these disciplined activities. The combined approaches of proactive engagement and intelligent integration demonstrate our unique capabilities that deliver greater value to employers.

CIGNA HealthCare and CIGNA Behavioral Health are ahead of our competitors in recognizing the mind/body connection and removing barriers to treatment. Together we offer:

- Health Management: Health Advocacy is demonstrated through an integrated care management approach fully leveraging the resources of medical, behavioral, pharmacy, and disability to facilitate better outcomes. Additionally, CBH provides a premier clinical delivery model that focuses clinical resources on consumer advocacy and care management while eliminating traditional utilization review processes that no longer add value.
- Consumerism: Consumerism includes improved consumer engagement and promotion of self-help programs focusing on behavior change. It includes health navigation and wellness through high-touch services provided directly to the consumer and a broad range of telephonic and online programs.
- Actionable Information: Enhanced reporting demonstrates CIGNA HealthCare and CBH's ability to provide meaningful reporting and discernable outcomes that give TennCare a comprehensive view of the health of their population.

CBH provides care for all members including those with Serious Emotional Disorders and Severe persistent mental illnesses. CBH also handles all customer service, claim and appeal services for mental health.

**2. Please describe your medical management model for care coordination and service integration between behavioral health providers and physical health providers, in particular an individual's primary care provider. Please describe your experience with ethnically and racially diverse populations in physical health and behavioral health settings.**

CIGNA Behavioral Health (CBH) is a leader in developing innovative models and programs for medical/behavioral integration aimed at improving the overall health status of the patients we serve. We recognize the importance of integrating behavioral and medical care to best serve participant populations, as clinical integration ensures an appropriate combination of primary care and behavioral intervention while treating "whole health" participant need.

Effective integration of medical and behavioral care promotes the various levels of wellness, which lead to optimum health care. CBH understands the value of such integration, which is why we work so closely with primary care physicians and collaboratively support significant wellness, clinical interface, and administrative integration initiatives.

CBH acknowledges that primary care physicians (PCPs) come with different degrees of psychiatric training, investment, experience, and competency. As a result, we work with a variety of models that allows the PCP to access the level of intervention that is most appropriate for their level of training, the type of plan, and the best needs of the patient in terms of such issues as confidentiality or integration of treatment, including the use of psychotropic medications.

Additionally, psycho pharmacy management is one of CBH's highest priorities. CIGNA Behavioral Health has a long track record of partnering with Pharmacy Benefit Managers (PBMs) to analyze psychotropic utilization patterns and positively influence the prescription patterns of physicians. We know that for most employer groups the fastest area of expenditure growth is in the use of pharmaceutical agents. Typically, anti-depressants (namely SSRI's – Selective Serotonin Reuptake Inhibitors) represent the number one or two most costly drug classifications, with three of the top ten prescribed drugs being anti-depressants (e.g., Prozac, Paxil, and Zoloft).

Recognizing the fact that pharmaceutical expenses for psychotropic medications - namely, anti-depressants - are a major driver of healthcare inflation, CBH began intensively studying prescription patterns for anti-depressants with dozens of health plans and PBMs beginning in the mid-1990s. Our studies examined the prescribing practices of both PCPs as well as psychiatrists. Through this research we have developed targeted interventions including education initiatives to ensure a comprehensive approach to whole person health is applied to every case we manage.

Through our integration initiatives, it is the goal at CBH to achieve the following:

- Improve ability to identify those with co-morbid medical and behavioral conditions, and assure appropriate referral or treatment.
- Integrate mental health and substance abuse screening tools into the CIGNA Well Aware for Better Health[SM] programs.
- Develop analytical tools leveraging co-mingled medical, pharmacy and behavioral databases to identify participants with co-morbid conditions.
- Improve providers' care of patients with behavioral conditions commonly seen in primary care settings.

Examples of some of our current integration initiatives are described in the following table. Additional information is available on request.

| Program/Project | Description | Expected Customer Benefit |
|---|---|---|
| Well Aware for Better Health – Diabetes and Depression | Incorporated within Well Aware Program: depression screening for program participants with provider notification of screening results for follow-up evaluation and treatment of depression, as indicated; participant and provider education tools about diabetes and depression; and CBH case management consultation/referral. | Improve overall health and quality of life for participants with diabetes and depression (20 to 33 percent comorbidity in which depression is associated with increased medical complications from diabetes); reduce associated health care costs. |
| Primary Care Clinical Guidelines for Depression | Depression diagnosis and treatment guidelines for primary care physicians. | Improved identification and treatment of depression in primary care can result in better health outcomes and reduced medical expenses. |
| *A Physician's Guide to CBH* brochure | Information for primary care practitioners about CBH and when/ how to access behavioral health referrals. | (Re) acquaint PCPs with CBH for streamlined access to behavioral health services through CBH. |
| PCP Communication System | Automated CBH system that sends, with participant permission, referral notification and information to<br>PCPs and behavioral professionals about their mutual involvement in the participant's treatment, prompting coordination of care. | Increasing the communication and coordination of care between medical and behavioral professionals can improve the quality of care. |
| Primary Care educational offerings about behavioral health issues | Educational offerings about behavioral health topics, sponsored by CBH, have been provided to PCPs with medical Continuing Education Units (CEUs). | Increase PCP knowledge about behavioral conditions to improve participant health outcomes. |
| *Physician Dialogue* newsletters | Articles and editorial content on various behavioral health topics have been provided for Physician *Dialogue* newsletters, most recently on ADHD. | Education, resource information to improve clinical practice. |
| Medical and behavioral representation in determining health care policies and practices | Medical and behavioral practitioners are jointly involved in Councils to determine:<br>• Overall health policy<br>• Prescription drug coverage<br>• Coverage for emerging therapies, new treatments and advanced technologies<br>• Ethical standards | Ensure consistency and best practices across disciplines and throughout the organization. |
| Case Management | Case management processes are established | High-risk members will benefit from |

| Program/Project | Description | Expected Customer Benefit |
|---|---|---|
| Coordination | to identify and collaboratively manage appropriate cases with medical and behavioral risks. | screening and identification of possible medical and behavioral co-morbidities and from streamlined access to coordinated medical and behavioral healthcare services to improve health outcomes and cost effectiveness of care they receive. |
| Medical and behavioral collaboration between CBH and the 24-Hour Health Information Line | Access to behavioral health specialists 24/7 and coordination of services with CBH life events product. | 24-Hour Health Information Line nurses have immediate transfer capability to access behavioral health professionals for participant behavioral health needs and crises. |
| Behavioral and pharmacy collaboration between CBH and CIGNA Pharmacy | Coordination in identifying problematic practice patterns and targeted interventions around co-morbid patient management. | Identifies potential quality of care issues immediately by providing a fluid management, follow-up program that improves patient outcomes. |

**3. While the state believes that the proposed coordinated approach will improve continuity of care broadly, TennCare is particularly concerned with maintaining the highest quality of care for those individuals on our program with SED and SPMI.**

**a. Please describe your experience with these populations, including specific programs and interventions (e.g., early intervention, psychiatric rehabilitation and recovery).**

CIGNA Behavioral Health (CBH) takes utilization and case management processes to the next level – we determine interventions based on the participant's condition, benefits available, medical necessity and level of care required. This comprehensive process ensures appropriate utilization, cost management, and participant care while removing administrative hassles that do not add value. We call this blend of utilization management and case management activities our Care Advocacy Program.

Our highest priority is to address a participant's issues from a clinical standpoint and predicate our utilization and case management decisions upon evidence-based treatment guidelines and align care with each participant's unique situation. Utilization decisions are based upon appropriateness of care, service, and existence of benefits. Progress in meeting treatment goals is closely monitored and adjustments are made as the participant's condition changes.

*Inpatient Care Management*

Our utilization management program emphasizes achieving the best clinical outcomes for each individual case within the structure of the Level of Care (LOC) Guidelines and benefits available as well as using strategic population approaches to build and enhance network and care management tools. Key clinical processes include:

- Case planning and shaping: CBH clinicians review case information against Level of Care Guidelines and collaborate with the provider to marshal appropriate resources and assure that a treatment and discharge plan is in place
- Identification of teachable moments when the individual is most receptive to intervention
- Achieving clinical consensus with the provider/facility team within the parameters of evidenced-based practices, the LOC Guidelines, and benefits available
- Adding value to the treatment process by:
  - Using additional resources and creative options
  - Using a collegial exchange to introduce and enhance compliance with practice guidelines

– Reducing unnecessary utilization management interface when there is appropriate treatment

Inpatient Care Managers work closely with the treating facility as well as PCPs and other medical specialists to address the participant's clinical needs. Mixed services protocols are discussed and regular contact maintained.

CBH manages inpatient utilization through medical necessity indicators for appropriate treatment. CBH follows our Level of Care Guidelines in considering the appropriateness of any level of care – all basic elements of the Medical Necessity definition must be met. Services must be:

- in accordance with generally accepted standards of medical practice[1];
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness or disease; and
- Not primarily for the convenience of the participant or provider, and not more costly than an alternative service or sequence of services as least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that participant's illness, injury, or disease.

*Outpatient Care Management*

CBH is the first national behavioral care company to successfully end preauthorization for routine outpatient care. Our proprietary technology quickly detects and our specialized clinical teams intervene on high risk and clinically complex cases. By systematically identifying complex cases, we allow our Care Managers to concentrate on cases where their expertise and time is of most value through participant or provider outreach.

We incorporate principles of utilization review, case coordination, and targeted interventions to reach positive treatment outcomes for each participant. Our system identifies cases that require the focused attention of a care manager for early intervention and case shaping:

- Complex, high-risk cases: eating disorders, ADD/ADHD, Autism, adolescent cases, substance abuse cases
- Improve adherence to treatment guidelines: Medication inappropriate for diagnosis, no follow-up after inpatient discharge
- Benefit Limitations or Claims Abuse: 65 percent of benefits utilized, more than 25 sessions; claims coding issues or prolonged care
- Customer Driven Needs: Clinical needs, safety sensitive issues
- Participant Communication: Prevention programs and available services

**b. What structural or contractual design choices would you recommend to ensure the needs of these populations are met?**

We have an outstanding Care Advocacy Program (CAP). This program is structured so that Personal Advocates can spend more time on the telephone navigating SED and SPMI members (and/or their family) through the system.

Our Personal Advocates can answer benefit questions, set up appointments and send members and their families' educational materials.

The introduction of the Personal Advocate in the Care Advocacy Program allows Care Managers to spend time on more complicated cases such as SED or SPMI cases.

1 For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas, and any other relevant factors.

Also, the Care Advocacy Program insures that providers and facilities are adhering to the Clinical Practice Guidelines, which are consistent with the APA Clinical Guidelines, as they treat these illnesses.

CIGNA has an Intensive Care Management Program that is designed specifically for the SPMI population. This is a special Case Manager that works with a case coordinator to make sure the member gets the services they are in need of and coordinates multiple levels of care to ensure patient safety.

CIGNA Behavioral health has also just hired a Certified Child and Adolescent Psychiatrist who physically sits among Care Managers and works with both In-Network and Out-of-Network providers to ensure proper care is administered, especially for the SED population.

CBH also employees Autism Specialists. In addition, as part of the NCQA Accreditation, CBH has a tertiary Preventive Health Program for children with ADHD.

**c. Would your interest level in bidding be positively or negatively impacted if the state were to consider excluding these individuals from this proposal?**

As long as the appropriate data is provided, including these individuals would not impact our response.

**d. Would your response to (c) change if the state were to adopt an alternative, more limited or no-risk arrangement for this population?**

Yes, this is a major area of concern for CIGNA Healthcare. We would prefer to reply to the upcoming RFP with a limited or no-risk arrangement. CIGNA is fully prepared to provide our superior programs and capabilities combined with a strategic communication process on an administrative basis. CIGNA would also be willing to put financial guarantees on our programs and capabilities. The only way CIGNA would submit a bid on a capitated arrangement is if (1) Cigna is able to set the capitated rate annually basis on current utilization and demographic data or (2) the TennCare pre-determined capitated rate meets our financial need, again, based on current utilization and demographic data.

**4. Please describe your experience working with essential community providers such as community health clinics and community mental health agencies.**

Use of community resources is a collaborative process that allows a case manager to identify alternative resources for participants who have limited benefits, have exceeded their available benefit, or require a service that is excluded from their plan. This knowledge allows a case manager to take advantage of networks of community, government and social resources. Our CBH care management staff members encourage community resources and self-help education as appropriate treatment supplements. We assess satisfaction with the care provided through provider and member satisfaction surveys.

**5. Based on your experience coordinating physical and behavioral health services, do you have any specific recommendations regarding the design of the behavioral health proposal for TennCare? More specifically, what financial guarantees, if any, might be necessary to ensure appropriate funding for these critical services?**

The Health Advisor Program is an excellent program to ensure coordination between physical and behavioral services. Through the Health Advisor Program, complex cases are reviewed in a round table format (discussion including both Behavioral and Medical Specialists). In addition, CBH keeps track of all behavioral referrals made to medical and all medical referrals made to behavioral.

Secondly, in conjunction with CIGNA Rx, we have a program to ensure patients are compliant with a full course of antidepressant treatment. This of course prevents relapse of illness which could potentially result in re-hospitalization.

**B. Pharmacy Services**

**Pharmacy has been a key driver of expenditure growth in the TennCare program. In an effort to control pharmacy costs, the State carved-out pharmacy and contracted with a pharmacy benefits manager (PBM). The State intends to continue the current PBM contract and the carve-out of pharmacy services. The MCO, in conjunction with the PBM, will support all efforts to manage the pharmacy benefit, including, but not limited to, provider education; identification and monitoring of outlier prescribers and users; and coordination of prescriptions across providers.**

1. **Please describe your approach to a pharmacy carve-out, including specific information on your approach to pharmacy management and cost containment strategies.**

   CIGNA can interface with any pharmacy benefit manager (PBM), although we prefer to provide a fully integrated medical/pharmacy program using our own integrated retail and mail order pharmacy program - CIGNA Pharmacy Management. There is an initial set up fee and an ongoing maintenance charge for interfacing with third party PBMs.

   We discuss the specifics around the type of information being requested to share and the need as part of the normal plan administration.

   *Eligibility Feeds*: Optional service fees include a one-time initial set-up fee and a monthly maintenance fee. Information is shared via a secure line on a weekly basis. The transmission complies with HIPAA Privacy Regulations.

2. **In a pharmacy carve-out scenario, what "real-time" information would you need to manage the benefit? Please be specific.**

   *Care Management/Disease Management*: Requests for sharing information for care management/disease management purposes are driven by the client and are coordinated through the account manager, sales representative, or implementation manager. A meeting is held with the account manager/sales representative, client, a PBM representative, and a HealthCare Economics representative to discuss specific needs, technical coordination, security issues, timing of monthly information transfer, and other pertinent issues. All information is shared in a secure format, compliant with HIPAA Privacy and Patient Confidentiality regulations.

   PBMs are required to provide data in a format acceptable to CIGNA. We provide the data elements/dictionary to the PBM. The account manager or sales representative works with the PBM and customer to help ensure compliance with data requirements. To help ensure we can apply our disease management selection logic, we require all pharmacy claims data.

**C. Long-Term Care Services**

**Long-term care services (nursing facility and services through home and community based waivers) will be carved-out of the MCO benefit package. However, individuals receiving long-term care services (including the aged, blind and disabled population) will be enrolled in MCOs for their acute and behavioral health services.**

1. **Please describe your methods and procedures for coordinating acute and long-term care services to reduce gaps in services and prevent duplication of services.**

   CIGNA case managers utilize key principles within the framework of nursing case management established by the American Nursing Association. Case management assessment is designed as a comprehensive approach to problem solving. CIGNA incorporates an automated case management assessment tool in our Integrated Care Management System (ICMS).

2. **What incentives would you recommend including in the MCO contract to drive home and community-based services as a viable alternative to institutional care?**

   CBH is always looking for alternative forms of treatment for an individual and will work within the individual's specific benefit plan.

   Custodial care is one type of alternative care available. Care is given in a protected, structured, supervised, and controlled environment, whether in an institution, or a community-based setting. Custodial care status may be identified when there is no reasonable expectation that with continued treatment, the participant's level of functioning or medical condition will improve. Custodial status may be temporary or permanent.

   Another type of alternative care is the 23 Hour Crisis Bed. This process provides an opportunity to evaluate participants when the participant is presenting in an apparent emergency evaluation that does not immediately reveal the needed level of care. This setting provides around-the-clock nursing care and continuous observation to ensure the safety of the participant and/or others. A face-to-face psychiatric evaluation is preformed immediately prior to or within the first six hours of admission. In addition, the facility has the capacity to provide a complete medical evaluation, tests, and procedures as indicated. The focus is to assess and resolve the immediate crisis so the participant is stabilized and can enter into other forms of treatment as appropriate.

   Child and adolescent psychiatric intensive outpatient treatment is an alternative that provides multi-modal treatment for participants who can maintain some ability to fulfill family, student, or work activities. This multi-disciplinary treatment plan is essential for participants facing severe psychological stressors and potentially complex family dysfunction.

   Community resources are often an important component in behavioral care management. Although these resources are not the primary form of treatment, they play an ancillary role in the participant's ongoing support and education.

   We also offer alternative treatment programs and support materials online at our website, www.cignabehavioral.com. These treatment options allow participants to utilize health programs and treatment methods in the privacy of their own homes.

**D. EPSDT Incentives**

**As part of the TennCare Middle Region reform the State is focusing efforts on enhanced EPSDT screening rates and compliance with the periodicity schedule. The State is considering the use of incentives to reward MCOs that achieve specific targets.**

1. **Please describe your current approach to EPSDT services, including your outreach and education component. In addition, if you currently use physician incentive programs to increase participation in EPSDT please describe these initiatives. Also, please provide us with your recommendations regarding the proposed incentives for MCOs, including appropriate and measurable targets, and meaningful incentives.**

   The central focus of CIGNA Wellness Programs is consumer engagement. Our programs guide consumers through a process that promotes health:

   - Information that results in knowledge;
   - Knowledge that empowers choice; and
   - Choice that improves health.

   Growing out of our industry-leading health management strategy, our full range of Wellness offerings addresses the needs of the whole person through an approach we call 360° Consumer Engagement℠.

   This approach links the two drivers of consumer health improvement:

   - *Consumerism*: Consumers claim a greater stake in health care decisions by means of education, incentives, web tools and more.
   - *Health management*: Consumers are guided to the most appropriate, high-quality care and advice by means of a wide range of resources – including proactive care management and health coaches.

360° Consumer Engagement is the cornerstone of our commitment to improve health, a commitment we measure through a patent-pending reporting tool called the CIGNA Health Improvement Score system.

A key measurement of the Hi Score system is consumer engagement, including the tracking of healthy behaviors such as the use of available wellness services and programs.

CIGNA Wellness programs were developed to address a wide range of needs, from education to clinical intervention. Many of our Wellness programs and services are included at no charge to the employer or member. These include:

- Health risk assessment tools – Web MD® Health Quotient
- Decision support tools – Hospital quality comparison tool, provider locator and quality assessment, Web and telephonic health library
- Clinical outcome improvement programs – Member and provider outreach
- Nurse hotline – 24-Hour Health Information Line SM
- Maternity education – Healthy Babies
- Targeted health education
- Preventive health guidelines and reminders
- Member newsletter – Well-Being
- Member discount program – Healthy Rewards
- Member assistance program
- Enrollment education

**E. Utilization Management/Medical Management**

**Essential to controlling the current rate of TennCare expenditure growth is a comprehensive and successful utilization and medical management program. As described above, Tennessee intends to have service limits for various benefits, and the MCO will be responsible for managing care within those limits. The proposal currently before the Federal government would allow the State to implement "hard" benefit limits. The only exceptions would include services on the "short list", which would not count toward benefit limits and continue to be available to enrollees after benefit limits are hit. However, the State is considering moving toward "soft" benefit limits in the future, where services beyond the benefit limit could be provided as cost-effective alternatives to covered services. The MCO would have the lead role in deciding whether to provide services over the applicable benefit limits. The State expects that these services would be authorized using a prior authorization process.**

1. **Please describe any experience you have managing care in a state with benefit limits, including both "hard" and "soft" limits. In particular, please describe any experience you have had implementing prior authorization processes as a mechanism to authorize services in excess of benefit limits. Please describe the prior authorization process you would employ for "soft" limits and the general criteria that would be utilized to evaluate requests.**

   *Inpatient Pre-Certification*

   We require inpatient pre-certification for all non-emergency inpatient admissions. Additionally, the following procedures require review for clinical medical necessity:

   - Obesity surgery
   - Major skin procedures
   - Face/jaw procedures (except trauma)
   - Transplants
   - Breast reduction
   - Hysterectomy (except cancer surgery)
   - Experimental or investigational

- Back/spine (except trauma, malignancy)
- Unlisted codes, category III codes

Our approach to pre-certification is geared towards encouraging the practice of high-quality, evidence-based medicine. Annually, we conduct a rigorous clinical and financial analysis to determine those procedures that are included on our pre-certification list. We review the medical literature and consider customer, provider, and member feedback. We then look to identify areas of potential over-utilization and to balance issues such as return on investment, provider satisfaction, and medical cost impact. The goal is to provide the most clinically and cost-effective standard of care for our members.

*Case Management*

CIGNA case managers utilize the key principles within the framework of nursing case management established by the American Nursing Association. The components of our case management program include:

- Case identification, screening and selection;
- Case assessment;
- Care plan development;
- Care plan implementation;
- Monitoring and evaluation of the case management plan; and
- Discharge from case management/case closure.

*Outpatient Pre-Certification*

We perform outpatient pre-certification to ensure clinical necessity for the following procedures:

- Potential cosmetic or reconstructive procedures, such as:
  - Skin removal or enhancement
  - Lipectomy
  - Breast reduction
  - Breast enlargement or surgery for gynecomastia
  - Treatment of varicose veins
  - Specific eye, ear and nose procedures
  - Erectile dysfunction
- Any surgeries on the Inpatient prior authorization list performed on an outpatient basis
- CT, PET scans, MRI
- Infertility treatment
- Gastric bypass
- Oral/TMJ
- Uvulopalatopharyngoplasty (UPPP)
- Acupuncture
- Biofeedback
- Speech therapy
- Cardiac/Pulmonary/Vestibular rehabilitation
- External prosthetic appliances (specific listing of codes)
- Durable medical equipment (specific listing of codes)
- Home health infusion
- Injectable drugs (specific listing of codes)
- Services provided by a non-participating provider

- Unlisted codes
- Experimental and investigational

*Medical Referrals*

Our referral management program is designed to help members access the appropriate level of specialty care from network providers. The referral management process is a cooperative effort between:

- The primary care physician (PCP), who coordinates specialty care for patients by generating the referral request to participating specialty care providers;
- The specialty care provider, who provides specialty services and coordinates continuity of care with the PCP; and
- The health facilitation center that supports referral management with technology and tools.

*In-Network Referrals:* When specialist, hospital or ancillary services are necessary, the PCP may assist the member with selecting a provider from a list of participating providers and authorize a referral.

*The primary care physician (PCP) can coordinate all aspects of a member's medical care and uses a referral to authorize medically appropriate care.*

The PCP provides written documentation of the referral to the specialist or referred provider. The PCP is also required to document in the member's medical record that the referral was made and why.

*Out-of-Network Referrals:* We permit referrals to out-of-network providers only if participating providers in the network are not able to render the required services. The health plan must approve out-of-network referrals in advance, except in emergencies.

The PCP must justify an out-of-network referral and request the health plan to authorize coverage. Primary care physician referrals to non-physician professionals, such as nurse midwives, social workers, optometrists, chiropractors, and counselors, also require pre-approval.

*Pharmacy Prior Authorization*

Generally, all injectable medications except for insulin and sumatriptan (Imitrex) require prior authorization. Examples of other drugs that require prior authorization and their indications include:

- Proton Pump Inhibitors for greater than eight weeks - Gastrointestinal disorders
- Viagra and similar agents - Erectile Dysfunction
- Celebrex - Osteo and rheumatoid arthritis
- Diflucan - Fungal infections
- Sporanox - Fungal nail infections
- Lamisil - Fungal nail infections
- Chorionic Gonadotropin - Infertility
- Somatropin - Growth Hormone Deficiency
- Intron A - Neoplastic Disorders
- Lupron - Uterine Fibroids, Infertility, Neoplastic Disorders

**2. Based on your experience, please provide any recommendations regarding specific UM/MM requirements for the State to consider, particularly the use of "soft" limits.**

We will be happy to discuss further utilization and medical management when we receive a definition of "soft" limits. We have also provided more background around our programs at the end of our RFI Binders.

**F. Disease Management**

***Physical Health***

**The State intends to incorporate the principles of disease management into its reformed managed care program and a comprehensive and coordinated approach will be expected of all participating MCOs. At a minimum the expectation would be that the MCO apply disease management techniques to the following physical health conditions:**

**Diabetes mellitus, Congestive heart failure, Coronary artery disease, Asthma, Chronic-obstructive pulmonary disease and High-risk obstetrics.**

1. **Do you have a formal disease management program? If yes, where is it currently being used, e.g., which State Medicaid programs?**

   **Again, if yes, on which conditions does your program focus today?**

   Yes. CIGNA brings you our disease management program, CIGNA Well Aware for Better Health[SM].

   Well Aware offers a potent combination of education, intervention, and coordinated ongoing care management. Built on a foundation of nationally recognized clinical guidelines and protocols, the program emphasizes self-care, giving participants the information, resources and support they need to take control of their condition and enjoy better overall health.

   CIGNA Well Aware for Better Health[SM] is an innovative care management program designed to:

   - Help your employees effectively manage chronic health conditions and improve their quality of life through education and support activities.
   - Make it easier for participating physicians to deliver consistent quality care and improve medical outcomes by providing education and reports on best practices, nationally recognized clinical guidelines, and member specific information.
   - Control medical costs by emphasizing prevention and early identification of medical problems.

   The Well Aware program focuses our medical management skills where they can have the greatest effect, by identifying the conditions where we have the best opportunities to improve medical outcomes, impact quality of care, and control medical costs. Currently, the conditions targeted are:

   - Asthma
   - Diabetes
   - Low Back Pain
   - Cardiac Conditions (coronary artery disease and congestive heart failure)
   - Chronic Obstructive Pulmonary Disease (COPD)

   As of January 1, 2006, additional conditions targeted will include:

   - Depression
   - Targeted (Impact) Conditions
     - Acid-related stomach disorders
     - Atrial Fibrillation
     - Decubitus Ulcer (commonly known as pressure ulcers or sores),
     - Fibromyalgia
     - Hepatitis C
     - Irritable Bowel Syndrome
     - Inflammatory Bowel Disease
     - Osteoarthritis
     - Osteoporosis

  - Urinary Incontinence
- Obesity
  - High Risk Obesity
  - Comprehensive Weight Loss
  - Specialty Case Management for Bariatric surgery

CIGNA supports early prenatal care and member education by providing open access to participating OB/GYN providers and no co-payments for maternity care after the initial office visit.

The CIGNA case management and utilization review activities help bridge the gap between intensive neonatal inpatient services and a child reaching a high level of activities in daily living. Our network of neonatologists, intensive care units, and support services are available for baby and family, through case management.

Premature infants with significant complications such as congenital anomalies, hydrocephaly requiring shunt placement, or respiratory complications are referred to neonatal case management.

The CIGNA HealthCare Healthy Babies® program focuses on cases with potential or actual risk factors, and provides case management intervention where appropriate.

CIGNA encourages pregnant members to call as soon as they receive confirmation of their pregnancy, so they can take advantage of educational materials available and so the member can be informed of available access to a registered nurse for information 24 hours a day, seven days a week, availability to myCIGNA.com, and screening for case management for high risk.

High-risk maternity cases include multiple birth pregnancies (triplets or more), and complications and/or co-morbidities identified such as hyperemesis, hypertension, diabetes, etc.

CIGNA offers complex and specialty case management programs. Case management activities and interventions are custom tailored to meet individual needs and assigned to a complex or specialty case manager.

Our LIFESOURCE organ transplant program includes the services of our dedicated transplant case managers, who manage the care of transplant patients through all phases of the transplant process. This dedicated unit ensures effective and efficient service to both the transplant patient and the provider. All services are provided under the support and guidance of a dedicated LIFESOURCE medical director, a transplant physician.

We recently introduced unique specialty case management programs for Catastrophic, NICU (Neonatal Intensive Care Unit), Oncology, Rehabilitation/extended care facility, and High-risk Maternity.

Our specialty case management programs recognize to ideally drive improvements in these areas, we need expert teams to work with members and their physicians more effectively. These expert teams will ensure coordination and completeness of complicated care plans, and enable our members to be informed and active in treatment decisions and compliance.

Keys to the success of these programs include:

- Specialized case management teams consisting of dedicated, certified nurse case managers with expertise and training in each therapeutic area, who work collaboratively with specialty physician leads; and
- Targeted tools for each program that help the teams identify and monitor program participants, enhance care coordination, address gaps in care, and help members get the most from the health care process.

*High-Risk Maternity Case Management*

High-risk Maternity Case Management program focuses on identifying pregnant women who may be at high risk for pregnancy-related complications and prenatal hospitalizations because of co-morbid medical conditions, such as hypertension and diabetes. Cases are stratified into risk categories to provide optimal coordination between the treating physician and home care providers. The overall goal is to reduce risk through patient education, member compliance, and appropriate patient care.

Specific program components include:

- Enhanced tools for early identification and optimal management;

  - Screening tool to identify potential high risk pregnancies with stratification; and
  - Case management tools used to drive action and intervention by identifying gaps in care.
- Maternity care integration rounds to address medical, behavioral, pharmacy, dental, disability, and disease management needs;
- Prenatal and post-partum depression and stress screening and management;
- Information on oral health during pregnancy;
- Targeted health educational material for high risk conditions; and
- Seamless integration with, and referral to, the NICU specialty case management program.

*NICU (Neonatal Intensive Care Unit) Catastrophic Case Management*

The NICU program focuses on achieving superior outcomes for our smallest members, where hospital stays can be prolonged, traumatic, and expensive. Involvement of NICU specialty nurses and neonatologists is critical for going beyond efficient arrangement of services, to the development of the most appropriate care plan. We seek to appropriately reduce the length of stay for these infants through resolving barriers to discharge, and facilitating parental education and use of community resources. Our specialized nurses will follow infants while in the NICU and also after discharge to the home, while case management needs exist.

Specific program components include:

- Enhanced case management tool that assists the case manager in facilitating a safe, timely discharge;
- Focus on care plan progress and the ability to identify and facilitate safe and timely discharge;
- Ensuring communication for the transition of care to the receiving pediatrician; and
- Specialized training and resources for case managers.

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- Focus on care plan progress and the ability to identify and facilitate safe and timely discharge;
- Ensuring communication for the transition of care to the receiving pediatrician; and
- Specialized training and resources for case managers.

*Catastrophic Case Management*

The Catastrophic Case Management program focuses on achieving superior outcomes for our most severely ill patients. The overall goal is to reduce avoidable hospitalizations and emergency room visits through patient assessment, patient education, and encouragement of doctor-patient discussions at clinically appropriate levels.

Specific program components include:

- Enhanced case management tool which assists the case manager in helping the member understand the diagnosis and treatment plan;
- Depression screening; and
- Co-management with inpatient case manager and specialty case manager when member is in the hospital or extended care facility.

*Oncology Case Management*

The Oncology Case Management program focuses on improving the quality of care and life of members with cancer, who are at highest risk or have the greatest need. The overall goal is to reduce avoidable hospitalizations and emergency room visits due to complications with chemotherapy and inadequate pain management.

Specific program components include:

- Enhanced case management tool that assists the case manager in helping the member to understand the diagnosis, treatment plan, chemotherapy side effects, and pain management;
- Depressing screening;
- Early hospice referral;
- Clinical trial participation; and
- Identification of facilities recognized for their care of the cancer patient.

*Rehabilitation Case Management*

The Rehabilitation Case Management program serves members who need admission to acute rehabilitation, skilled nursing facilities and long-term care hospitals. The program focuses on improving efficiency and effectiveness of the review process for these admissions, ensuring quality care and service. The overall program goal is to provide a smooth transition for the patient via a focused pre-admission review. Once they are admitted to the most appropriate level of care, their care is monitored, barriers to safe and timely discharge are addressed, and post-discharge follow up is conducted to ensure that all care needs are met once the patient leaves the treatment setting.

Enhanced tools for the program include:

- Level of care screening tool;
- Documentation and interaction case management tools for guiding action and intervention; and
- Depression screening.

**2. Is the function fully performed within your organization or do you subcontract with another entity? If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured.**

CIGNA partners with American Healthways, a disease management specialist, to provide you and your employees with the best in program administrative services. American Healthways was chosen to partner with CIGNA due to its long, successful experience in the disease management industry. American Healthways has over 20 years of experience working with people who have chronic conditions.

CIGNA Well Aware for Better Health[SM] is termed a hybrid method. The program was developed by both CIGNA and American Healthways.

All other medical management programs are operated by CIGNA.

3. **Please describe your disease management approach, and address each of the above conditions specifically. Include in your description how you identify individuals in need of disease management interventions more broadly (including potential future high-cost utilizers); your outreach and education approach; the number of individuals served; your approach to physician behavior, including the use of clinical guidelines; staff qualifications; your experience and approach to managing within the context of benefit limits; and a description of measurable outcomes resulting from the disease management intervention. Please also describe what additional health conditions you might recommended for targeted intervention techniques (e.g., obesity, pain management)?**

The Well Aware program focuses our medical management skills where they can have the greatest effect, by identifying the conditions where we have the best opportunities to improve medical outcomes, impact quality of care, and control medical costs.

*Selection*

Members are selected for CIGNA Well Aware for Better Health[SM] based on a stringent set of rules or algorithms that were developed by our care management team, in association with clinical experts. Depending on the disease or condition, we survey medical and pharmacy claims and laboratory results monthly to identify members who meet the criteria for inclusion in a program. Members who have not yet generated claims are identified through medical management activities, may self enroll, or may be enrolled at the request of their participating physician. Other sources of identification are through the health risk assessment (HRA) and predictive modeling.

Chronic disease is different for each person who experiences it. Individuals with the same condition can have widely varying needs, depending on their disease severity, complications, knowledge level and self-care abilities. The Well Aware programs are designed around these differences. Through our excellent information management and integration capabilities, we handle the complexities of disease management across an entire employee population – while making each program responsive to individual needs. It all starts with identifying potential candidates.

We proactively identify potential participants for Well Aware. We look at a combination of data from medical claims and encounter data, and the laboratory and pharmacy claim systems based on specific disease related codes, International Classification of Diseases (ICD-9) and Current Procedural Terminology (CPT-4) codes. The specific information used depends on the disease. Participants may also be referred or self refer into Well Aware programs.

*Claim Criteria*

We survey medical and pharmacy claims to identify potential Well Aware participants. Twelve months of claim data are interrogated on a rolling basis to identify Well Aware members.

Here are some examples of the criteria we use:

- Asthma:
  - Inpatient claims – one or more inpatient admissions for asthma;
  - Outpatient claims – two or more outpatient services for asthma; and
  - Pharmacy claims – two or more asthma-related drugs dispensed.
- Diabetes:
  - Inpatient claims – one or more inpatient admissions for diabetes;
  - Outpatient claims – two or more outpatient services for diabetes; and
  - Pharmacy claims – two or more diabetes drugs dispensed.
- Low Back Pain:

  - Medical claims are used to identify potential low back pain program participants. One medical claim satisfying the low back pain diagnosis code will identify a potential participant.
- Cardiac Conditions:
  - A history of coronary artery disease, including myocardial infarction, ischemic heart disease and/or angina.
  - Congestive heart failure:
    - One or more inpatient admissions for coronary heart disease (CHD);
    - One or more outpatient encounters with a CHD-related diagnosis code; and
    - One encounter with a CHD-related procedure.
- Chronic Obstructive Pulmonary Disease (COPD):
  - One or more inpatient services coded with an ICD-9 diagnosis of COPD;
  - One or more emergency room visits coded with an ICD-9 diagnosis of COPD; and
  - At least two physician or specialist office visits coded with an ICD-9 diagnosis of COPD.

*Referrals*

Participants also may be identified for Well Aware through referrals. These include:

- Utilization management and case management referrals, through medical management activities;
- Physician referral;
- Self-referral, through contact with customer services; and
- Referrals from the CIGNA 24-Hour Health Information Line$^{SM}$ and health risk assessment.

*Resources and Outreach*

*A Full Range of Support Services:* Well Aware calls on the full resources of CIGNA to reach out to participants with the help, support and information they need for better health. Below are our current communication methods. We are also working on developing a communication strategy for the TennCare population since we realize our current methods will not completely work for the TennCare enrollees.

- *Nurse consultants*: Call participants to answer questions, offer support and ensure that self-care goal plans are followed. Telephonic education and support call frequency is dependent upon the participant's disease severity.
- *Telephonic Education:* Telephone calls are used as a tool to:
  - Welcome a participant into the program;
  - Remind participants of important screenings, tests, and immunizations; and
  - Monitor participants in order to provide frequent follow-up interventions which help them accept and follow the program recommendations and guidelines for self-care.
- *Specialists*: Certified diabetes educators, certified case managers, registered dietitians and respiratory therapists are just a toll-free call away. Participants can call for answers to questions about their condition, treatment, medication and self-care.
- *CIGNA HealthCare 24-Hour Health Information Line$^{SM}$*: Available around the clock for answers to health-related questions, help with self-care, and access to our library of recorded programs on hundreds of health topics.
- *myCIGNA.com*: Gives Well Aware participants access to general information about the program, as well as updates on the latest health care topics. They will also find links to the national expert groups such as the American Diabetes Association and American Heart Association.
- *Employee articles and other materials*: Posters, payroll stuffers, and newsletter articles are some of the resources that can be made available to employees and included on your company's intranet.

CIGNA provides Well Aware participants with comprehensive materials and tools for each program.

*Asthma*

For Maintenance Members:

- Introductory letter with opt out provision;
- Welcome packet including a letter and age-appropriate workbook;
- Toll-free telephone access to a nurse on the Well Aware team;
- Periodic reminder cards;
- Flu/Pneumonia vaccine reminders;
- Educational materials upon request; and
- Assessment of condition stability.

For Active Members:

- Introductory letter with opt out provision;
- Welcome packet including a letter and age-appropriate workbook;
- Welcome call from the Well Aware team;
- Education and care calls from a nurse on the Well Aware team;
- Ongoing toll-free telephone access to the Well Aware team;
- Periodic reminder cards and calls;
- Flu/Pneumonia vaccine reminders;
- Educational materials upon request;
- Quarterly asthma newsletter;
- Regular assessments of condition stability, and move to "maintenance" level when appropriate;
- Quality of Life survey;
- Satisfaction survey (random sample); and
- Depression screening.

*Diabetes*

- Introductory letter, welcome call and welcome kit (all participants and all severity levels);
- At introduction and annually: Quality of Life survey (all participants and all severity levels);
- At introduction and annually: Depression screening (all participants and all severity levels);
- Quarterly: Newsletter (all participants and all severity levels);
- Annually: Health Status Report (all participants and all severity levels);
- As needed/ongoing: Toll-free clinical hotline (all participants and all severity levels);
- Once during program: General Health Assessment (Levels Two, Three and Four);
- At introduction and as updated: Self-care goal plan (Levels Two, Three and Four);
- Every six weeks: Clinical care calls (Level Two);
- Every four weeks: Clinical care calls (Level Three);
- Every two weeks: Clinical care calls (Level Four); and
- Annually: Satisfaction survey (random sampling of all participants).

*Low Back Pain*

- Introductory letter with opt out provision;
- Welcome packet including letter and an action plan to be completed with their physician;

- Ongoing one-on-one toll-free telephone access to a Well Aware team nurse;
- A baseline problem-specific assessment conducted by phone to determine member's level of functioning and the types of educational support and reinforcement needed;
- A depression screening conducted at program entry, and annually thereafter;
- Ongoing problem-specific assessment;
- For members with more severe low-back conditions (Levels Two and Three):
  - A minimum of two calls within six months for Level Two members; or
  - Three calls within six months for Level Three members.
- Educational materials – selected to meet the member's needs, based on the problem-specific assessment;
- Periodic reminders – Flu/Pneumonia vaccine in September, standards of care reminder mailed annually; and
- Satisfaction survey (random sample of participants).

*Cardiac Conditions*

- Introductory letter with opt out provision;
- Welcome kit including a toll-free telephone number, personal calendar, standards of care, and health care tips;
- Welcome call;
- Reminder postcards, telephonic reminders of important screenings, tests, and immunizations;
- "Cardiac Outlook" – quarterly newsletter;
- General Health Assessment to identify modifiable risk factors;
- Quarterly maintenance telephone calls to participant;
- Health education services; and
- Annual health status report.

*Chronic Obstructive Pulmonary Disease (COPD)*

- Introductory letter with opt out provision;
- Welcome kit including a toll-free telephone number, personal calendar, standards of care, welcome letter, COPD workbook, health care reminder stickers and health care tips;
- One-on-one telephone welcome call from a nurse on the Well Aware team consisting of:
  - A baseline problem-specific assessment conducted by phone to determine member's level of functioning and the types of educational support and reinforcement needed;
  - A General Health Assessment to identify modifiable risk factors and;
  - A depression screening conducted at program entry and annually thereafter.

*Targeted (Impact) Conditions*

- Introductory letter with opt out provision; and
- Welcome kit including a toll-free telephone number, personal calendar, standards of care, welcome letter, health care reminder stickers and health care tips.
- One-on-one telephone welcome call from a nurse on the Well Aware team consisting of:
  - A baseline problem-specific assessment conducted by phone to determine member's level of functioning and the types of educational support and reinforcement needed;
  - A General Health Assessment to identify modifiable risk factors; and
  - A depression screening conducted at program entry and annually thereafter.

*Obesity*

- Introductory letter with opt out provision; and
- Welcome kit including a toll-free telephone number, personal calendar, standards of care, welcome letter, health care reminder stickers and health care tips.
- One-on-one telephone welcome call from a nurse on the Well Aware team consisting of:
  - A baseline problem-specific assessment conducted by phone to determine member's level of functioning and the types of educational support and reinforcement needed;
  - A General Health Assessment to identify modifiable risk factors; and
  - A depression screening conducted at program entry and annually thereafter.

*Depression*

- Introductory letter with opt out provision;
- Welcome kit including a toll-free telephone number, personal calendar, standards of care, welcome letter, health care reminder stickers and health care tips;
- One-on-one telephone welcome call from a nurse on the Well Aware team consisting of:
  - A baseline problem-specific assessment conducted by phone to determine member's level of functioning and the types of educational support and reinforcement needed; and
  - A General Health Assessment to identify modifiable risk factors.

***Behavioral Health***

**In addition, the following behavioral health conditions are targeted for care management interventions:**

**Schizophrenia, Bipolar disorder, Major depression and co-occurring mental illness/substance abuse**

Major depression has been added to our disease management program CIGNA WellAware for Better Health – as of January 1, 2006. That program has been fully described earlier.

*Intensive Care Management Program (ICM)*

CBH knows that participants with certain clinical conditions require a more intense level of case management. After a six year-long Six Sigma project focusing on inpatient admissions and readmissions, CBH identified the following high-risk populations for the ICM program:

- Females, ages 40-49 with a primary diagnosis of Bipolar Disorder
- Females, ages 40-49 and males, ages 50-59, with a primary diagnosis of Substance Abuse and a secondary diagnosis of Major Depression
- Females, ages 40-49 and males, ages 30-39, with a primary diagnosis of Major Depression
- Any member with a diagnosis of Psychotic Disorder

Thus, the purpose of our Intensive Case Management Program (ICM) is to improve the quality of life for participants through services including, but not limited to, assistance with appointment reminders, coordination of services between multiple providers, education and empowerment, and assistance in managing the participant's available benefits.

ICM is a free, voluntary service and confidentiality will be protected at all times. Participants are invited to participate in the program via letter, and can opt out if desired. CBH will be happy to work with the State to create programs for other conditions.

**4. Does your care management program include behavioral health conditions? If yes, where is it currently being used?**

Depression screening is a component of all of our disease management programs. Participants receive an annual depression screening assessment. If a participant screens positive, we ask the participant for permission to share the information with their treating physician. If the participant agrees, we send the depression screening notification to the physician and suggest they may want to do a further depression assessment.

- Depression will be the second most prevalent cause of disability within four years (Source: World Health Organization, 2000).
- Successful antidepressant treatment results in annual medical cost savings ranging from $1,000 to $1,500 (Source: McCombs, 1990; Revicki, 1998)

The prevalence of depression in the diabetes population ranges up to 37 percent, over four times that of the general population. In those with diabetic complications, 35 percent have severe depression and 39 percent have a milder form of clinical depression. Diabetics with depression have poorer glycemic control, less adherence to treatment regimens, and have 86 percent higher total health costs. Even the partial relief of depressive symptoms can yield annual savings of over $1,500 per patient in medical expenses.

Depending on the condition and point in time, the prevalence of depression in cardiovascular patients range from 20 percent to 75 percent, with the most likely rate exceeding 40 percent, with one-third of patients without clinical depression at the time of a myocardial infarction (MI), eventually becoming depressed within the next 12 months. Mortality rates post-MI are four to six times greater if the patient has depression, and patients with depression experience longer stays or more frequent re-hospitalizations, and are slower to return to work.

5. **Is the function for behavioral health care management fully performed within your organization or do you subcontract with another entity? If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured.**

   Behavioral health care is provided CIGNA Behavioral Health (CBH).

6. **Please describe your care management approach to behavioral health conditions, addressing each of the above conditions specifically. Include in your description how you identify individuals in need of disease management interventions; your outreach and education approach; approach to co-morbid mental and physical conditions; the number of individuals served; your approach to provider behavior, including the use of clinical guidelines; staff qualifications; your experience and approach to managing within benefit limits; and a description of measurable outcomes resulting from the management intervention.**

   The CBH care management philosophy is founded on our belief that behavioral disorders are caused by the interaction of genetics, personal developmental history, and social environment. Therefore, care management is a multi-disciplinary team activity. We have similar expectations for treatment in our provider network, particularly for severely ill patients.

   We believe many behavioral disorders are preventable and all can be effectively treated. We also believe treatment plans should be individualized and benefits should support a full continuum of care and all available, qualified treatment options. For example, in areas of scarce resources for children, it is common for CBH to credential developmental pediatricians, allowing them to bill under a mental health code and collaborate with a psychiatrist on our staff.

   CBH believes ensuring crisis stabilization in ambulatory settings and robust follow-up post hospitalization are our most critical care management functions.

   Behavioral issues are intrinsic to serious physical disease management, and most behavioral disorders are treated in primary care, family practice, and internal medicine settings. Therefore, our programs and networks must be integrated with medical management providers. We have a mission to improve the detection and treatment of behavioral disorders in medical settings.

   Participants access their behavioral health services by calling 1.800 CIGNA 24. This toll free number includes a specific prompt for behavioral health services and where callers can speak with a Personal Advocate. Personal Advocates discuss several referral options with the caller, who then chooses the provider that works best for their needs. Personal Advocates find providers who:

   - Specialize in the caller's presenting problems.
   - Meet the caller's stated needs in terms of credentials, language, age, gender, etc.
   - Is located within a reasonable distance from home or work, depending on the caller’s preference.

   The same level of service is provided during both normal business hours and after hours by the CIGNA Behavioral Health CBH After Hours Team. This team is available from 4 p.m. to 9 a.m. (CST), allowing CBH

to offer behavioral care services 24 hours a day in all time zones. In addition, the team triages individual crisis situations, reviews benefits, manages care, makes referrals to appropriate resources, and coordinates benefit services for all levels of care.

CIGNA Behavioral Health views care management as a continuum, with the severity and complexity of a case guiding the level of involvement and appropriate interventions. Routine cases generally require less intensive intervention while more complex cases benefit from greater involvement. The CBH Care Advocacy Program includes targeted workflows that ensure treatment is evidence based and is consistent across our care managers. CBH clinical staff defined condition-specific interventions based upon literature findings, research, population studies, and data mining. These staff members continually evaluate interventions, review metrics and update operational processes as needed.

CBH takes utilization and case management processes to the next level – we determine interventions based on the participant's condition, benefits available, medical necessity and level of care required. This comprehensive process ensures appropriate utilization, cost management, and participant care while removing administrative complications.

Our highest priority is to address a participant's issues from a clinical standpoint. We predicate our utilization and case management decisions upon evidence-based guidelines and align care with each participant's unique situation. Utilization decisions are based upon appropriateness of care, service, and existence of benefits. Progress in meeting treatment goals is closely monitored and adjustments are made as the participant's condition changes.

The CIGNA Behavioral Health (CBH) Level of Care Guidelines were developed by a multidisciplinary task force of physicians, nurses, psychologists, social workers, and substance abuse clinicians all from within CBH, as well as external "experts" in a variety of specialties, convened by the National Medical Director for Quality.

**G. Capitation Model**

**Under the TennCare reformed managed care model the State will be returning to capitated managed care.**

1. **Please describe your experience operating under a risk contract for Medicaid and any concerns or recommendations associated with this approach.**

   Our previous Medicaid experience has been on an administrative services only funding arrangement.

2. **Please indicate if a full-risk capitation environment would negatively or positively affect your decision to participate.**

   Given the current environment and financial circumstances of the TennCare program a full risk capitation environment would not be acceptable to CIGNA. We encourage the State to consider other funding mechanisms and willing to work with you to develop a new and innovative manner of risk sharing.

3. **The State is committed to a capitated approach for the core benefit package, as described above, for all enrollees. If you prefer an arrangement other than full risk, however, please describe the mechanisms you would prefer, such as:**

   a. **State supported stop loss provisions based on annual per member expenditures (e.g., the state reimburses X% of costs between $X and $X per member per year)**
   b. **If the State adopted "soft" benefit limits, State supported stop loss provisions based on per member benefit utilization (e.g., the state reimburses X% of hospital visits over the 20 day annual limit)**
   c. **If the State adopted "soft" benefit limits, aggregate risk sharing**
   d. **(e.g., the state reimburses X% of costs in excess of X% of capitation payments)**
   e. **Other**

   All or some of the above mechanisms could be used in a shared risk arrangement. Talks with the State and negotiations will be necessary to determine the best way to finance this program.

4. **Does your participation depend upon a minimum number of covered lives? If yes, what is the minimum number?**

   Our participation does not depend on a minimum number of covered lives.

**H. Data and Systems Capability**

**Critical to the success of the program is the availability of robust, timely data, including encounter data, for use by the State and MCOs to manage and monitor the program. The State is very interested in MCO capacity to obtain and provide data and reports to the State, and capacity to use data for ongoing program monitoring and quality assurance.**

**1. Please list and describe data, including encounter data, and reports you have experience producing for external monitoring. Please list those states for whom you provide this information.**

The reporting needs of the TennCare program may differ from the needs of our standard customers and we are ready to work with the State to develop a reporting package to meet those needs.

To give you an idea of the types of reports that we have available now, the quarterly Health Care Trend and Cost (HCTC) report package is designed to provide key information to help you manage health plan benefits and maximize the return on your investment. Most of our utilization reports include normative data for comparative purposes. Due to patient confidentiality and privacy concerns, specific patient and member identifiable information is not provided. A description of each utilization report is provided below.

*Analysis of Medical Fee-For-Service Submitted Charges*: Displays the breakdown of submitted charges, ineligible charges, and eligible charges.

*Medical Fee-For-Service Eligible Charges by Dollar Range*: Details medical costs and utilization within dollar ranges based on eligible charges.

*Distribution of Medical Fee-For-Service Submitted Charges by Major Diagnostic Category – Inpatient Facility*: Details actual utilization and costs by major diagnostic category (e.g., respiratory, circulatory, etc.) for total medical fee-for-service submitted charges with detail by the inpatient facility setting.

*Inpatient Facility Total Utilization and Costs*: Summarizes utilization and costs within the inpatient facility setting.

*Distribution of Medical Fee-For-Service Submitted Charges by Major Diagnostic Category – Overall Cost for both Inpatient and Outpatient*: Details costs by major diagnostic category (e.g., respiratory, circulatory, etc.) for total medical fee-for-service submitted charges with further detail by inpatient and outpatient setting.

*Facility Outpatient Utilization and Costs by Service Category*: Displays outpatient facility utilization per 1,000 members and average medical fee-for-service submitted charges for surgery, diagnostic testing, emergency room, and all other.

*Professional Inpatient Utilization and Costs by Service Category*: Identifies professional inpatient utilization per 1,000 members and average medical fee-for-service submitted charges for surgery, anesthesia, radiology, maternity, and other services.

*Professional Outpatient Utilization and Costs by Service Category*: Identifies professional outpatient utilization per 1,000 members and average medical fee-for-service submitted charges for office visits, surgery, anesthesia, radiology, newborn care, and other services.

*Catastrophic Claim Statistics*: Identifies the number of claimants per 1,000 members with accumulated fee-for-service eligible charges in excess of $50,000 for a specified time period.

*Utilization by Age Category*: Outlines utilization and costs within specific age bands.

*Utilization by Gender*: Outlines utilization and costs by gender.

Our financial robust reporting package is designed to provide key information to help you monitor your benefit plan's performance on a quarterly basis with monthly data. This reporting package has been developed for customers whose renewal increase is partially or completely based on experience. The robust package can be provided at no additional cost. A description of each report is provided below:

*Incurred Claim and Membership Information (for managed care business)*: Provides data split by month for billed premium; claims split between fee-for-service, capitation, pharmacy, and opt-out; and an incurred loss ratio.

*Incurred Claim and Subscriber Information (for PPO or Indemnity business)*: Provides data split by month for billed premium, claims split between fee-for-service and pharmacy, opt-out, and an incurred loss ratio.

*Shock Claim Information*: Identifies number of shock claims (claims over pooling point) and amounts; does not include names, Social Security numbers, or any identification of claimants.

*Utilization Data*: Contains utilization data for in- versus out-of-network, type of service, and admission category.

The CIGNA Benefit Insight Program is our unique approach to analyzing a client's medical and pharmacy plan performance and providing actionable recommendations for product, plan design and medical management options. This program allows CIGNA to help customers learn from experience — theirs and ours—and enhance the performance and experience of their health benefit plans. Through this consultative process, we are able to help the client in gathering and analyzing available information to identify the drivers of medical trend, translate the drivers into actionable steps, and recommend product and benefit designs that are most beneficial to the client. Essentially, we not only help the clients to understand their plan "experience," we also help them to learn from that experience for designing future plans.

*Premium Program*

Under the premium program, information gathering and analysis is provided by our information advisors and consultants within the CIGNA Information Management (CIM) department. Data is updated as often as requested by the information advisors and consultants. These advisors and consultants also work closely with medical directors and pharmacy managers to deliver quantitative and quality results. The results are then presented to the State of Tennessee in a customized fashion.

**2. Please describe how and what data you use to monitor, measure, and evaluate your performance, including the performance of your network providers and any subcontractors. Please be as specific as possible.**

CIGNA shares with our providers a commitment to improving quality outcomes. We achieve this through a provider quality strategy that promotes patient safety through quality measurement and information sharing.

Our provider quality strategy consists of the following elements:

*Relevant and Actionable Metrics*

We work to improve the quality and performance of our networks by applying metrics that integrate and leverage both industry-recognized and evidence-based information. A key element here is our provider metrics tool, which allows us to compare the practice patterns of participating providers and identify quality of care issues and potential best practices.

*Targeted Outreach and Information Sharing*

CIGNA takes an active, integrated approach to sharing clinical care information to recognize high performance and to improve outcomes when lower performance is identified.

*Recognition*

Our strategy seeks to encourage quality through a variety of recognition programs to reward excellence, help change practice patterns and improve care.

In addition, through the CIGNA Quality Management Program, which is based on industry standards and objective measures, we evaluate the quality of care and services received by CIGNA members. The program also helps us focus on improvement efforts.

The Quality Management Program includes the following:

*Credentialing/Recredentialing*

All physicians belonging to a CIGNA network undergo careful review of their qualifications in accordance with our national credentialing requirements. As part of the credentialing process we review the physician's education and training, licensure status, board certification, hospital privileges, and malpractice history.

*Medical Record Review*

As part of our quality management review process, we perform an Ambulatory Medical Record Review (AMRR) on a random sample of network physicians with more than 50 CIGNA members as patients. Reviews of medical records allow us to monitor the overall quality as well as the continuity and coordination of care our members receive.

*Member Concern and Appeals Review*

Through the Member Concerns and Appeals Review monitors, we evaluate and resolve member concerns as well as identify opportunities for improvement in the quality of care and services. We collect and analyze data related to administrative, quality of service, and quality of care issues and determine trends and opportunities for improvement. We share appropriate information with our providers.

CIGNA employs robust analytical tools to profile physicians on quality, to track and compare practice patterns and monitor cost and utilization. Individual providers can be compared to their specialty group in their own geographic area. The tools provide valuable insight into variations in the practice patterns, with the ability to account for clinical differences in patient populations. Once these differences are understood, the information needed to identify opportunities for improvement is available. This set of analytical tools allows us to complete the following activities:

- Identify trends, which help with contracting or medical management interventions to manage their provider networks;
- Identify potential best practices and benchmark these individuals or groups;
- Identify providers who are high and low outliers;
- Identify quality of care issues by targeting under care situations and tracking specific clinical conditions from episode of care results; and
- Conduct consultative sessions with providers geared toward helping them understand their results, where they vary from their peers and how they can improve.

CIGNA utilizes many innovative physician profiling and performance measurement activities. The following provides a description of these activities.

*Primary Care Physician Preventive Health Report*

Preventive health metrics are monitored using HEDIS Effectiveness of Care (EOC) metrics. Physician scores are also compared to same specialty peers in the same geographic area. The Physician Preventive Health Report is produced twice a year. Metrics include:

- Comprehensive Diabetes Care
- Breast Cancer Screening
- Cervical Cancer Screening
- Coronary Screening
- Beta-blocker Treatment After Heart Attack
- Cholesterol Management After Acute Cardiovascular Event
- Prenatal Care
- Immunization Management

*Episode Treatment Groups (ETGs)*

CIGNA Provider Metrics tools incorporate ETG and episode risk group (ERG) methodologies licensed by Symmetry Health Data Systems, Inc. ETGs are a severity adjusted illness classification system that clusters distinct episodes of care. In all, there are 558 episode classifications. ETG reports are available for almost all physician specialties. ETGs provide a consistent, reliable method to measure and compare costs and utilization and include case mix adjustment to account for differences in patient severity.

ETGs classify an entire episode of care that includes outpatient care, inpatient care and ancillary services (including lab, radiology, pharmacy, etc.). The ETG methodology identifies and tracks clinical activity for as long as an illness is actively treated. ERGs use the ETGs along with member eligibility information to create a retrospective risk assessment for individuals, which CIGNA then applies to providers to compare the severity/case mix of a physician's panel to the peer group.

*Disease Management Information Outreach and Intervention*

Regular communications are sent to the physicians regarding their members with conditions that are currently being managed by a program, a prescription, or both. These communications include:

- *AlertLink for Physicians*: The CIGNA Well Aware for Better Health® *AlertLink for Physicians* is a patient-specific outreach and intervention program for physicians who care for members who participate in Well Aware programs. The report lists members of the treating physician who have not had a certain standard of care measure that is recommended for their particular disease. The report is produced once a year.
- *Medication Lists*: The Medication List captures pharmacy claims as well as member self-reported information of over-the-counter medications. A member's knowledge is assessed on prescribed dosage and reason for taking the medication. The clinician can then assess for drug to drug interaction and compliance.
- *Depression Screening Notification*: If a participant screens positively for depression, we ask if we can share this information with his/her treating physician. The provider is then sent a copy of the depression screening notification suggesting that they may want to do a further assessment to determine a diagnosis of depression.

*The CIGNA Pharmacy Facilitation Program:* This physician-directed program focuses on pharmaceutical errors, gaps and omissions and is an example of targeted outreach and intervention with providers. We use prescription, medical and lab claims history to identify an opportunity for improvement or a member at risk. Specific programs include:

- *Pharmacy Facilitation Program for Asthma*: This program focuses on the overuse of "reliever" without "controller" therapy. We identify omission of asthma controller therapy without increasing the use of short acting beta-agonist inhalers. We communicate directly to the provider, notifying them of the treatment improvement opportunity.
- *Pharmacy Facilitation Program for Cholesterol*: This program targets members who have both CIGNA medical and pharmacy benefit coverage. Through integrated data sources, our Cholesterol Treatment to Goal program identifies members whose LDL cholesterol levels are not at an appropriate level even though they are taking cholesterol-reducing medication.
- *Antidepressant Medication Management*: This program is integrated with CIGNA Pharmacy Management and CIGNA Behavioral Health. Through integrated benefit management, the program is aimed at improving quality of antidepressant utilization and treatment of depression for all members with CIGNA Pharmacy benefits. The antidepressant provider profile with integrated medical, pharmacy, and behavioral data identifies physicians with the greatest opportunities for care improvements measured by appropriate diagnosis, appropriate length of therapy as well as medication waste.

**I. Net Worth and Restricted Deposit Requirements**

**In addition to the statutory net worth and restricted deposit requirements for HMOs, TennCare MCOs must comply with contractual net worth and restricted deposit requirements. The statutory net worth requirement is made on an annual basis based on historical data (see TCA, Section 56-32-212). The MCO contract requires that the minimum statutory net worth requirement be recalculated before a significant enrollment expansion occurs. In terms of reserves, statutorily MCOs must maintain a restricted deposit in the amount of $900,000 plus specified amounts of premium revenue in excess of $20 million (see TCA, Section 56-32-212). The MCO contract requires MCOs to maintain a restricted deposit equal to the statutory net worth requirement. This requirement will be revised to clarify that the increased restricted deposit amount shall be calculated based on the MCO's TennCare revenue, unless that amount is less than the restricted deposit required by statute.**

**If the amount calculated using only TennCare revenue is less than the restricted deposit amount required by statute, then the contractually required amount shall be equal to the restricted deposit required by statute.**

1. **Do you consider the net worth and depositing requirements to be a deterrent to contracting with TennCare? If so, please explain.**

   No, this will not be an issue.

**J. Implementation Timeframe**

**The State's anticipated timeframe for the procurement and implementation of the TennCare Middle Region reform calls for bid procurement in January, with selection of MCOs in April and service delivery beginning in October. MCOs and any subcontractors accepting risk (e.g., BHOs) will have to be appropriately licensed in Tennessee prior to implementation.**

1. **Does the anticipated timeframe of an April 2006 contract award and an October 2006 implementation date impact your decision whether to participate in the program? If yes, how?**

   This time frame would have no impact on our decision. We will be happy to work with the State to implement our program by October 2006.

2. **Do you have suggestions or recommendations regarding the procurement and implementation timeframe? What is your recommended minimal and optimal timeframe between contract award and implementation?**

   Our standard implementation time frame is 90 days. With the communications challenges that face this plan more time may be needed. We would like an opportunity to discuss at length the needs with the State so that an effective implementation calendar can be created.